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What is Gender Dysphoria? A Critical Systematic Narrative Review

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What is Gender Dysphoria?: A Critical Systematic Narrative Review

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For Peer Review

Abstract

In the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders, the American Psychiatric Association has changed the diagnosis of Gender Identity Disorder to Gender Dysphoria (GD). In this critical narrative review we ask: What is Gender Dysphoria? We report on some of the inconsistencies in the papers that foreground distress while obfuscating the fact that not all trans and intersex people suffer stress or impaired functioning; and the inappropriate referencing to intersex people in the diagnostic criteria, claims about the GD diagnosis contributing to the depathologization of, and reducing stigma surrounding trans people, the conceptualizations of 'gender dysphoric' research subjects and finally we question the etiological approaches using GD as a conceptual framework. We further suggest that there are a number of methodological issues that need to be resolved in order to be able to claim that the GD diagnosis can be validated. In order to shed light on these paradoxes and methodological issues in the *DSM-5*, we report on the content validity of GD by reviewing research papers post diagnostic inception. These findings will contribute to the debate about the validity of GD as a diagnosis for the 21st Century for those people who need to live a different gender to that assigned at birth.

Introduction

There is an existing controversy about how diagnostic texts address medical interventions related to gender transition.¹⁻³ In the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders: DSM-5* (DSM-5), the American Psychiatric Association (APA) has changed the diagnosis of Gender Identity Disorder (GID) to Gender Dysphoria (GD).⁴ The *DSM-IV*'s⁵ diagnosis of GID assumes that diverse gender identities are inherently disordered and consequently perceived by many to be stigmatizing (see analysis below). A review of GID was therefore a key focus in developing the *DSM-5*'s diagnosis of GD. On the APA's webpage titled *DSM-5 Development* it stated that from 2007 until the end of 2012 each work group met and reviewed *DSM-IV*'s strengths and problems, from which research questions and hypotheses were developed.⁶ Moreover, they stated that literature reviews, targeted research analyses and a review of clinical expertise followed from which a draft *DSM-5* diagnostic criteria was developed and then a final approved manual was released in May 2013.

Significantly, however, in terming the new diagnosis 'gender dysphoria', the APA adopted a term that was already well used within popular and academic discourse to describe experiences of distress within gender diverse populations, but which had not previously been a diagnosis. Making use of existing and familiar terminology with a goal to reduce pathologization is potentially counter-productive if the result is lack of clarity over how terminology is being used. In particular, there is a danger that a term that is now the name of a specific, diagnosable psychiatric disorder may simultaneously be applied to individuals, populations or experiences that do not meet diagnostic criteria and that, according to the APA, should not be considered pathological. In this paper, we explore how the concept of 'gender dysphoria' has been

narrativized within the scientific literature since the introduction of the *DSM-5* in 2013, with a particular focus upon how far current academic usage reflects the diagnostic criteria.

The emphasis upon distress was one of the main reasons for changing GID to GD, as indicated in a memo from the members of the work group tasked to update the diagnosis. The memo states: “This proposed name change is also consistent with the general argument that the diagnostic term should, in a more transparent way, indicate that it pertains to distress”^{7: 902} as the clinical problem and not the gender identity. The full list of ‘new’ diagnostic indicators are: “a strong desire to be rid of one’s primary and/or secondary sex characteristics because of a marked incongruence with one’s experienced/expressed gender,” “a strong desire for the primary and/or secondary sex characteristics of the other gender,” “a strong desire to be of the other gender,” and “a strong conviction that one has the typical feelings and reactions of the other gender.” Additionally, in the *DSM-5*, GD “is associated with clinically significant impairment in social, occupational, or other important areas of functioning”^{4: 452-3}. An added advantage of the name change, it was also argued, was the elimination of the pathologizing effects of the GID diagnosis.⁷ However, there is a curious caveat in the manual that clearly states that “not all individuals will experience distress as a result of [...] incongruence”^{4: 451} in spite of a strong desire for medical interventions, such as psychological therapy, hormone therapy and/or surgeries to alleviate what the authors assert are patients’ perceived incongruence between their gender identities and bodies.⁸ Additionally, there is a post-transition specifier^{4: 453} within the manual, which enables clinicians to apply a code for health insurance reimbursement for those trans and intersex people who require ongoing treatments, but have no (more) signs of dysphoria.

The diagnosis of GD therefore encompasses some social and psychological factors and some forms of desire within the wide ranging ‘symptoms.’ We suggest, however, that the

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3 diagnosis contains a few fundamental paradoxes. Firstly, it is far from transparent how the new
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5 diagnosis of GD is supposed to fully relate to distress and not identity if distress is not
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7 necessarily present. Secondly, earlier in the DSM-III⁹ the authors excluded intersex conditions
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9 from the diagnosis of GID; however, they could be diagnosed in the *DSM-IV*⁵ under the
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11 diagnostic category “GID Not Otherwise Specified,” which distinguished those who were
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13 experiencing severe identity conflict.¹⁰ The diagnosis of GD now includes intersex people
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15 comparably to trans people if their clinically assigned sex at birth causes them “distress” for at
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17 least six months, or they are experiencing two or more symptomatic indicators. It is unclear
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19 which indicators can capture intersex people in relation to a marked incongruence with their
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21 experienced/expressed gender and identification with *the other gender*, or desire to be of *the*
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23 *other gender*, or a strong conviction that one has the typical feelings and reactions of *the other*
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25 *gender*. What is the *DSM-5* referring to by writing “the other gender”^{4: 453}? It seems to us that
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27 there is no inherent, singular “other gender” in relation to intersex people’s gender.
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33 We noted above a statement from the APA arguing the ability to translate the findings
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35 that had been ‘found’ during the evidence review process into a workable diagnosis. A workable
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37 diagnosis’ validation should be open to public scrutiny and, moreover, would be dependent on
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39 the design, sampling strategy, weight of evidence, and most importantly research question.
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41 Despite these stated principles, the necessary details do not appear to have been released for
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43 public scrutiny. This obfuscates the difficulty of translating the many potential studies’ research
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45 findings that used sophisticated research methods across the different scientific communities.¹¹
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48 The diagnosis of GD, we will argue, cannot be validated according to what the scientific
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50 community claim to be standard methodological principles.
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3 In order to shed light on these paradoxes and methodological issues, we report on a
4 narrative review where we sought to explore the narrativization of GD post its inception as a
5 diagnosis within the *DSM-5*. The present study is a narrative review, asking simply: What is
6 Gender Dysphoria? We answer this by investigating whether and to what extent the narratives in
7 the published literature relate to the diagnostic criteria and narrative depiction in the *DSM-5*. We
8 also assess how the scientific community narrativize the concept of GD and the extent to which
9 this is influenced and shaped by the diagnostic criteria, symptomology, and description within
10 the DSM 5. We did this by conducting a multi-disciplinary systematic narrative review. The
11 rational for this is that the GD diagnosis is often used in multiple ways in the academic and
12 pedagogical contexts, which we suggest is inevitable because of the confusion noted above. As
13 such, the importance of garnering an understanding of the GD diagnosis and its usage in
14 published literature across all disciplines will highlight its potential paradigmatic influence in
15 social, psychological, medicolegal contexts, alongside its actual validity as a diagnosis for the
16 21st Century for those people who need to live a different gender to that assigned at birth.

37 **Controversial psychiatric diagnostics**

38 Gender Dysphoria Syndrome was first used in a paper by Fiske,^{12: 388} who claimed that the term
39 developed out of clinical necessity and grew in an “organic and naturalistic fashion” and
40 furthermore attended to the rise in demand from people needing to transition from their assigned
41 birth sex. The term “dysphoria” stems from the Greek meaning difficult to bear. In the area of
42 gender and sexuality, Kutchins and Kirk^{13: x} show that within the APA’s organizational processes
43 of developing diagnoses a “strange mix of social values, political compromise, scientific
44 evidence, and material for insurance claim forms” are introduced. At the helm of diagnostic

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3 reform of the GID diagnosis was the Chair of the work group Kenneth J Zucker, who claimed
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5 that the change from GID to GD better describes the distress that some trans and intersex people
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7 experience when their gender identity is ‘incongruently’ experienced.see ¹⁴
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10 In relation to trans diagnoses, contestations have been widely documented.^{1,2,13-18} The
11
12 diagnosis was developed amidst demonstrations against ongoing psychiatric pathologization, by
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14 trans and intersex activists who were arguing against the draft diagnosis,see ^{1,19} the ‘therapeutic’
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16 approaches towards gender diverse children,^{2,20} and how the psychiatric diagnosis plays a
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18 fundamental part in insurance based healthcare provision and legal recognition requirements in
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20 many parts of the world.¹
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24 Another political controversy posits skepticism on the submitted scientific evidence
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26 gathered for/by the work group for the development and ‘improvement’ of the diagnosis.see ^{14,21}
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28 Creators of the GD diagnosis claimed that the science used to underpin its development was
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30 rigorous. However, it is impossible to scrutinize such claims, since the discussions,
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32 methodological processes and promised field trials of the diagnosis have not been published.
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34 Even if the evidence were available for scrutiny, it is likely that the meta-reviews would have
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36 been based on a heterogeneous range of methods, design and paradigmatic approaches and while
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38 in principle this could have been eventually standardized, there would be substantial difficulties
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40 in doing so. In particular, it would be necessary to synthesize studies using a range of different
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42 terms, such as transsexual, transgender, GID and GD into an overarching GD diagnosis. Such
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44 terms represent at once identity positions and (different) symptomatic conditions. Nonetheless,
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46 the evidence that was used was judged by the APA committee members and board of trustees to
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48 be sufficient enough to formulate the GD diagnosis.
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Science and the *DSM*

At the DSM's inception, science about gender and sexuality was of little importance and diagnoses were based on moralistic clinical perceptions.^{13,16,22,23} Apparently this changed in the lead up to publishing the DSM III, which was advertised as using scientific standards, empirical investigation and data to develop diagnoses that can endure empirical scrutiny¹³ However, critics have suggested that in the following manifestation *DSM-IV-TR*²⁴ the diagnosis of GID lacked scientific rigor, resulting in stigmatizing effects, and that the criteria constructed trans people's identities as disordered because they expressed their genders differently to stereotypical masculinities and femininities associated with their assigned sex.^{14,25} Moreover, professionals working in the field of gender transitions and diagnostics critique the previous diagnosis of GID for its dependence on fixed categories of gender and gender role expressions and behaviors and, also, argued that there was a lack of reliable and valid diagnostic criteria.²⁶⁻²⁹

The APA's website³⁰ sets out its approach to rating 'scientific data', with double-blind randomized control trials considered to be the best. In the event of a gap in high quality research evidence work groups should review (subjective) clinical observation data and come to a consensus. Clinical data and consensus, is low on the APA's scientific scale, because it is highly unreliable and dependent on the views of clinician(s). Such data is inevitably influenced by clinicians' political leanings, and paradigmatic approaches to psychiatry. Clearly, it is neither practically possible nor ethically appropriate to conduct double-blind randomized control trials upon interventions related to gender transition. As a consequence, the validity that was reported³¹ underpinning the diagnosis of GD was primarily reliant upon clinical consensus: evidence that is considered by the APA to be relatively low quality and reliant on a relatively limited amount of scientific evidence drawing on the research of a small number of psychiatrists/sexologists.

There is limited evidence within the public domain of systematically evaluating the reviews that took place during the *DSM-5* revision process. Nonetheless, the change from GID to the new diagnosis of GD was pitched as a product of a democratized process, considering broader knowledges and demonstrating the diverse phenomenology of trans and intersex people.³² The APA offered two periods for public feedback, inviting opinion and criticism about gender issues, resulting in the third largest category to receive input for the *DSM-5*'s revision process,³³ it is unclear how these contributions were used or assessed leading Ansara and Hegarty²¹ to conclude that the 'synthesis of evidence' was created by an invisible network of researchers who contribute to the ideological delegitimization of trans (and now intersex) people's own classifications of their genders and bodies.

Validity and reliability

A few studies have attempted a dimensional assessment of gender dysphoria in different populations. For example, Cohen-Kettenis and van Goozen³⁴ reported on the psychometric properties of the Utrecht gender dysphoria scale (UGDS) that has poles that range from not dysphoric to dysphoric, and which consists of 12 questions rated on a 5-point scale. They reported that the tool successfully discriminated "male" and "female" transsexuals from same-sex controls resulting in discriminant validity. Smith et al.³⁵ also used the scale to evaluate the outcomes of gender confirmation treatment outcomes reporting that gender dysphoria was totally eradicated in their sample following interventions. The GIDYQ-AA developed by Deogracias et al.^{36: 371} said that their GD scale worked with a "bipolar continuum with a male pole and a female pole and varying degrees of gender dysphoria, gender uncertainty, and gender identity transitions between the poles." In a recent study⁸ it was suggested that the two scales, although

both designed to measure the degree of GD will do so in a different ways because each instrument captures only some aspects of the construct. The report submitted to the APA³⁷ does not set out the methodology used to evaluate research used to develop the GD diagnosis. As such, it is impossible to assess the reliability or validity of the methodology. This maybe in part be due to the links not being populated on the APA website, leading us to assume that the field trials were not undertaken. There was the possibility of analyzing 10 pieces of research/reviews for establishing the GD diagnosis.³⁰ The studies consisted of literature reviews and secondary data analyses. However, the studies admitted to the review were not looking at distress but at gender non-conformity. Yet according to the *DSM-5* working group, the key distinction between the *DSM-IV* and *DSM-5* is the recognition that gender non-conformity and distress are not the same things, and that gender non-conformity is not pathological in its own right. Basing the diagnosis of gender dysphoria on studies of gender non-conformity, while simultaneously claiming to be depathologizing gender non-conformity, is clearly neither logical nor methodologically robust.

Quantitative researchers would normally use statistical methods to associate a new instrument's utility with existing measures in other instruments.³⁸ This was not possible in this instance, since the review was a secondary analysis of (qualitative) conclusions. Qualitative tools used in empirical literature reviews and in the evaluation of secondary data analyses cannot be validated using statistical criteria.^{39,40} The qualitative validity of the GD diagnosis could be assessed, in a commonsense way, through the credibility of an explanation, interpretation and observation if its use is consistent among clinicians and researchers, and *in the way it was intended*. This can be described loosely as content validity.⁴¹ There is then a possibility that content validity of GD could be determined by its consistent use in the literature and what ought

to have happened during the development process of constructing the GD diagnosis. Given that GD is a diagnosis primarily derived from an asserted scientific consensus, it seems appropriate to test it through exploring the degree of scientific consensus upon what GD is. We will attempt in the results of this current study to go some way in unpacking the content validity of the GD diagnosis after its inception in 2013.

Aim(s)

The present study is a narrative review, asking simply: What is Gender Dysphoria? We answer this research question by examining the content validity and investigating whether and to what extent the narratives in the published literature relate to the diagnostic criteria and narrative depiction in the *DSM-5*. In this article, we assess how the scientific community narrativize the concept of GD and the extent to which this is shaped by the diagnostic criteria, symptomology, and description within the *DSM 5*. We did this by conducting a multi-disciplinary systematic narrative review.

Because primary research varies within different research paradigms ontologically, epistemologically, theoretically and ideologically,⁴² a narrative review was chosen to understand the ways in which the diagnosis of GD is understood and used in contemporary peer reviewed literature. We took the stance that the narratives that are told about GD within the literature can be adequately understood through describing the narrative patterns therein. We assumed that the narrative patterns and the concept of GD were intrinsically entwined in such a way that the narrative impacts the concept and the concept impacts the narrative. Thus, it is now sensible to start enquiring into the diagnostic validity of GD in light of the literature that followed its *DSM-5* inception.⁴³ As such, this paper determines what GD is (in the literature), and then makes some

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3 observations about the conceptual rigor in the scholarly area of trans and intersex people, who
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5 continue to be, from our analysis, somewhat problematically depicted in academic fora. The
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7 importance of garnering an understanding of GD and its usage is to highlight its potential social
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9 and paradigmatic influence within academic contexts alongside the expediency of the diagnosis
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11 for the 21st Century.
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17 **Methods**

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19 A narrative approach to the research question: What is Gender Dysphoria? warranted very little
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21 exclusion criteria. We wanted to explore the ways that the concept was situated in the narrative
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23 structure of the articles. The concept of GD and its narrativization would be able to uncover the
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25 ways that it is utilized, explained, analyzed and tested for in (participant) samples, artefacts, legal
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27 statutes and policies within the published work. The term we used was Gender Dysphoria
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29 inclusive of the dates April 2013 and June 2016. The rationale behind choosing this yearly range
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31 was that “Gender Dysphoria” became the official diagnosis in the *DSM-5*.⁴ Moreover, the
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33 diagnosis would provide the framework from which an evaluation and understanding of how
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35 researchers, scholars and clinicians were narrating the diagnosis of GD in their work.
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40 The initial results from 46 health, psychology, science, social and humanities databases,
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42 yielded 5765 articles (see Table 1) EBSCO Host was used which searches all available
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44 databases. EBSCO Host reduced the number of retrieved literature to 2554 items in the printout,
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46 due to exact duplicates being automatically removed. After mining the database results manually
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48 we removed a further 1994 papers due to more duplication and by removing all news items
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50 leaving 560 articles. We mined further removing another 173 because they were commentaries,
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52 letters to editors, not in English or the term GD was only present in the correspondence address,
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keywords or in the name of a gender identity clinic and did not feature in the main body of the article. This left a total of 387 papers to analyze (see Table 2).

We uploaded all the papers into Endnote and each author was randomly allocated papers who then searched for the term GD. We cut and pasted the paragraphs in which GD featured and placed it into a document then uploaded it into NVivo to code inductively. We also read each of the articles to get a sense of the overall narrative and analytical framework. Each author produced codes separately. Each month the authors met and started to discuss the codes. We refined the coding framework at each meeting and discussed both the obvious substantive codes that we were both developing independently and the ‘outliers.’ The coding framework began to morph over a period of eight months into agreed upon sets of hierarchical coding, which we present in this article. Some coded paragraphs fit into more than one code and theme, depending on the narrative it told. These are important findings as they emphasize a complex, often conflated and repeatedly questionable use of the diagnostic concept.

Results

We ideographically developed a number of meta-data source-types to enable us to see if there were any patterns in the ways that disciplines, the geography of the paper and sample type impacted on the narratives of GD:

- Article-type – Empirical, Case Study, Reviews (meta-syntheses etc.), Discourse (legal and medical/healthcare frameworks).
- Country: Not applicable (reviews), Multiple Research Sites, Comparative Research, and 33 countries across the world.

- Discipline: Cultural, Psychology, Biology, Law, History, Social Science, Philosophy, Bioethics, Medical, Surgery, Misc. Therapies, Health Services, Religion.
- Referred to DSM-5 criteria: Yes/No.
- Research Samples: trans men, trans women, mixed trans adults, trans boys, trans girls, mixed trans children, mixed trans adult and children, transgender, genderqueer/non-binary, ‘Disorders of Sex Development’ (‘DSD’), cisgender, trans and ‘DSD,’ ‘DSD’ and cisgender, LGBT, Artefacts, Statutes, Policies, Fictitious (film and literature).

There were no discernable patterns garnered from the meta-data. Nearly 45% of papers referred to gender dysphoria as a diagnostic term for trans people and/or intersex people, and the remaining papers assumed gender dysphoria in their work without citing the *DSM-5*. The three major narrative themes we will be drawing on in this paper are: 1. Distress and Diagnoses, 2. Types of People with Distress, 3. Popular Discourses and Distress.

Distress and Diagnoses

Foregrounding “distress”

The number of papers that offered a description of GD from the *DSM-5* was 49% (see Table 3). This left 51% of the articles (see Table 2: references with *) that conceptualized GD in ways other than as a diagnostic concept, which we will comment on further below. Just over 46% of the articles that referenced the *DSM-5* however did not fully outline the diagnosis as it appears. These papers truncated the description, which resulted in an interpretation of the diagnosis that foregrounded arguments of “distress.” For instance, most of the papers suggested that the distress could be alleviated following the process of assessment and surgical interventions and that multi-disciplinary teams were the ones to diagnose and support any medical interventions necessary.

Only eight papers (just over 2% see Table 3: references with *) included a full description, such as Barry et als’,⁴⁴ who noted that the incongruence between gender identity and assigned sex does not interfere with all trans people’s lives; they are completely contented living just the way they are or may desire some forms of medical intervention, and it is only for a subset of transgender people, however, the incongruence results in gender dysphoria i.e., a feeling of stress and discomfort with one’s assigned sex.

Six of the papers including a full depiction of the diagnosis were reviews in psychology, one was from law and one article was from a group of clinicians working in a UK gender clinic who stated: “We have previously questioned the value of distress as a core criterion for diagnosis in DSM classification as it is a very general use of language, not specifically pathognomonic for any mental or physical illness, disorder or condition, and rather open to a wide range of interpretation as to what constitutes marked or clinically significant distress.”^{45: 165}

Depathologizes gender non-conformity

Quite a number of papers (14.5% see Table 4) endorse the *DSM-5* work group’s claims that the new diagnostic criteria serves to depathologize gender non-conformity. These ranged from ambitious claims, such as: “DSM-5 also recognizes gender identity in individuals as an option and not a stigmatized mental illness”^{46: 422} to lesser but no less problematic assertions, such as “the term ‘gender dysphoria’ has replaced gender identity disorder and this change in terminology removes the ‘pathology’ from being transgender, which is not a mental health condition.”^{47: 792} In addition, this and 5.7% (see Table 5) of other papers highlight that transgender identities are no longer considered a sign of pathology, but an aspect of human diversity. Semantically this may be true, however, they offer no indication of how or why the

change in name removes pathology from being transgender. The GD diagnosis within the *DSM-5* emphasizes “incongruence” between assigned gender and experienced gender, and sets out diagnostic criteria such as the desire to be treated as one’s experienced gender within society, or a conviction that one’s feelings or reactions are typical of people with the same gender identity. Wishing to be treated as a woman or man within society, or believing that one’s feelings are typical of one’s status as a woman or man, would plainly not be considered diagnostic indicators for cisgender people. As such, the diagnosis continues to assume that the gender identities of trans and intersex people should be regarded differently to those cisgender people. As Aiken⁴⁸ argues, while removing the word “disorder” from the diagnosis, the new entry in the *DSM-5* still maintains the notion that transgender or gender nonconforming individuals are mentally ill.

Diagnosis and stigma

Many of the papers (12% see Table 6) articulated that trans people and to a much lesser extent intersex people were often discriminated against, suffered much abuse and occupied a stigmatized position in society. Campbell et al.⁴³ review highlighted that much of the distress associated with trans and intersex people appears to reflect social stigmatization from negative reactions from family, friends, and society. While the majority of these papers acknowledged that psychiatric diagnoses can stigmatize populations, 3.1% (see Table 7) of the papers (including some that also suggested widespread discrimination and stigma) claimed that the change in nomenclature from GID to GD would reduce this stigma. Little evidence was provided for this claim, and it seems questionable to conclude that changing diagnostic terminology in a clinical manual would substantially address discrimination and stigma within wider society.

Not all trans and intersex people suffer from GD

The claimed destigmatizing and depathologizing effects in the literature were derived from the assertion in the *DSM-5* that it is the distress and not the gender diversity that is diagnosable. Despite this, many papers omitted the fact that not all trans and intersex people experience gender dysphoria. Arguments in the literature required the distress factor to conform to the distress merits medical intervention ideal. As such, papers only partially appropriate the *DSM-5*'s diagnosis in order to support claims that the diagnosis ensures clinical interventions by a multi-disciplinary team and that health insurance payments would unlikely be forthcoming without a diagnosis (7.9% see Table 8). A narrative about access to clinical interventions and health insurance payments on the basis of not suffering distress or impairment to social functioning would indeed seem odd.

To apply a diagnosis to all who require medical interventions and who do not suffer dysphoria or impairment to social functioning with a diagnosis of GD is also medically questionable. This is especially so for people who prior to them being offered medical interventions managed by multi-disciplinary teams to be the best course of clinical care. In these papers then, the psychiatric diagnosis functions as a gatekeeping check in socioeconomic climates, such as in the United States, that requires a diagnosis for medical interventions and/or the granting of legal gender recognition leaving the question whether a psychiatric diagnosis' validity should be about pathology or should it be used to aid any secondary gains, such as citizenship rights⁴⁹.

The post-transition specifier diagnosis was explained in just higher than 2% (see Table 9) of the papers, as a stage following some treatment and when the trans person requires ongoing treatment, but is 'no longer gender dysphoric' – no literature mentioned the post-transition

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3 specifier in relation to intersex people. The primary purpose of this post-transition specifier is to
4 facilitate medical insurance payments for ongoing interventions that may continue to occur after
5 distress has been resolved – for example to allow for ongoing hormone therapy.² Some of these
6 papers acknowledged this.
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12 The post-transition specifier was modeled on the concept of “remission,”⁵⁰ however, this
13 does not make much sense for non-dysphoric or non-impaired individuals who may have
14 transitioned. If someone is non-dysphoric/-impaired originally, then logically no remission of
15 dysphoria can take place. If the post-transition specifier of gender dysphoria is applied to non-
16 dysphoric/-impaired people this would result in a false positive diagnosis, which has further
17 implications for our analysis about the prevalence of gender dysphoria below. Because of the
18 confusing diagnosis, understandably, there has been a host of conceptual issues conflated in the
19 papers analyzed. Implicitly and explicitly presenting GD in this way results in a narrative of
20 distress that may not always be warranted and thus the validity of the diagnosis GD is brought
21 into question on grounds of the illogicality of remission, when the DSM states that not all people
22 suffer distress.
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40 **Types of People with Distress**

41 *GD prevalence*

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44 The rationale behind the GD diagnosis in the *DSM-5* was to offer clinicians a common language
45 and orientate them toward accurate and dependable diagnoses. Epidemiologically, some (7.8%
46 see Table 10) commented on the prevalence of GD. However, prevalence statistics were
47 typically derived from the numbers referred to gender clinics, implicitly suggesting that everyone
48 who is referred meets the diagnostic criteria for GD, which may not be the case (and, conversely,
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also assuming that everyone experiencing GD accesses gender identity services). There were numerous terminology confluences (transgender/transsexual/GID/GD) making it difficult to clearly understand the number of people actually suffering with GD because the classification systems used have varied over time. Many authors have used GD inconsistently within the papers on prevalence, for example, conflating gender identity disorder, gender dysphoria and transsexualism (52% see Table 10 references *). The diagnostic criteria for GID, GD and transsexualism may overlap, but are not identical. It therefore cannot be assumed that prevalence figures for one set of diagnostic criteria can be simply applied to another and consequently cannot underpin any validity claims.

Etiology

Similarly, a few papers (3.5% see Table 11) discussed questions about what ‘caused’ GD in biomedical terms. However, in almost all these cases they appeared to be looking at possible causes of incongruence between assigned gender and experienced gender, and not seeking the causes of distress. For instance, in a meta-synthesis Arcelus et al.^{51: 809} searched for “Transsexualism, gender identity disorder or gender dysphoria [which] must be diagnosed according to DSM-III, DSM-IIIR, DSM-IV, DSM-IV-TR, DSM-V [*sic*], ICD-9, ICD-10, or Benjamin criteria” to be included in their study. Other papers (3.5% see Table 12) argued that there were no discernable biological evidence of GD. The *DSM-5* explicitly states that diverse gender identities are not in themselves disordered, and disorder solely relates to distress. Yet the papers discussing GD’s ‘etiology’ in terms of seeking biomedical causes for a particular ‘non-conforming gender identity, clearly presumes that such identities themselves require medical explanation. Moreover, if the intention of research is to understand links between biology and gender identity, it is

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3 methodologically weak (and ideologically dangerous) to attempt to do so by looking solely at
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5 clinically-referred populations for whom gender diversity is causing distress or impairment.
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7 Moreover, the *DSM-5* clearly points to the existence of gender diverse populations who do not
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9 experience distress or impairment, prevalence studies then do not contribute to the validity of
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11 any tools determining GD.
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17 *Presumption of 'dysphoria' in a given population group*

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19 GD was used as a descriptor for a group of people, for example those who had a history of GD,
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21 those undergoing transitioning medical procedure or those who had been referred to a gender
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23 clinic, who may or may not have been diagnosed with GD. A large majority of papers did not
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25 make it clear whether “clinically significant distress” or social impairment had been established,
26
27 or even assessed by a clinician or the researcher. Other international diagnostic criteria in
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29 common use in the papers, such as the *ICD-10*'s⁵² gender identity categories, do not include
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31 distress as a criterion. It therefore, cannot be automatically assumed that patients accessing
32
33 gender services or undergoing transition medical procedures necessarily experienced distress,
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35 especially in jurisdictions where the *ICD-10* is used in preference to the *DSM*. In addition, the
36
37 post-transition specifier within the *DSM-5* also allows for the possibility that some people may
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39 have a prior diagnosis of GD, but not currently be experiencing distress. Inexact use of the term
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41 GD therefore carries a danger of presuming ubiquitous distress in a population group where
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43 levels of distress are in fact not known as we demonstrate below.
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51 *Research Samples and Gender dysphoric patients*

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3 Within research populations (14% of papers see Table 13), the timing or location of the
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5 fieldwork, the age of the participants, and in the case of intersex people prior to 2013 were
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7 diagnosable under different criteria and made it highly unlikely that the individuals researched
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9 had been diagnosed with GD. The timeframe required to make it into print, for some of the
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11 articles, would account for some of this discrepancy, however, not for all of them. As noted
12
13 above, only 2.5% of papers used the post specifier concept. Surprisingly however was that the
14
15 post-transition specifier was not used in all the papers describing the long-term follow up of
16
17 research participants who had previously received medical interventions related to their gender
18
19 identity. Such participants were described using terminology such as ‘gender dysphoric’ without
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21 reference to the possibility that their dysphoria might have been alleviated through the
22
23 interventions they had received. There is much evidence to suggest that various medical
24
25 interventions are desired and required by trans people.^{53,54} In most cases, this is to alleviate the
26
27 pressure of living a gender that they were not assigned at birth.^{55,56} The empirical basis for
28
29 treatment options and long-term outcomes with regard to intersex patient preferences is
30
31 insufficient.⁵⁷ Nonetheless, continuing to describe all trans and intersex people as ‘gender
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33 dysphoric’ long after treatment is inconsistent with the claims about the suitability and
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35 effectiveness of treatments received by trans (and intersex) people that were made within the
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37 very same papers.
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47 **Popular discourses within the literature**

48 *Hierarchies of Dysphoria*

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51 Several papers (4.6% see Table 14) described transsexualism as an extreme form of gender
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53 dysphoria, or stated that only people with extreme gender dysphoria would seek medical
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3 transition. This characterization that transsexualism is the most extreme form of GD and
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5 associated with a desire to medically transition, reifies and reintroduces hierarchies of need
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7 between trans, intersex and gender diverse people. The language about “extreme” GD in the
8
9 reviewed papers assumes that there is direct correlation between severity of distress and bodily
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11 intervention choices an individual will make. No evidence was provided in the papers to support
12
13 this implied correlation nor does gradated levels of gender dysphoria appear in current diagnostic
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15 texts.
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19 Older texts (notably Harry Benjamin⁵⁸), do directly posit a hierarchy in which there are
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21 ‘true’ transsexuals, who have the most extreme form of gender incongruence, and are presumed
22
23 to most likely to be ‘successful’ transitioners. Medical services have often been designed with
24
25 mental health professionals serving mainly as “gatekeepers” to gender-affirming hormone
26
27 therapy and surgery.^{59: 441} The gatekeeping is predicated on the assumption that it is clinically
28
29 important to distinguish between these ‘true’ transsexuals and individuals with other forms of
30
31 gender diversity, who are perceived to be more likely to regret interventions. However, the
32
33 concept of ‘true transsexualism’ is no longer present, and the current standards of care (SOC)
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35 emphasise the role of professionals to be supportive rather than gatekeepers. Papers that imply a
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37 hierarchy of gender dysphoria are therefore replicating outdated notions of the role of medical
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39 services.
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45 The persistence of this idea of hierarchy potentially derives in part from the apparent
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47 crossover between three different texts used in a majority of the medical/clinical papers: the
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49 *ICD-10*, *DSM-IV* and *DSM-5*. In the *ICD-10*, “transsexualism” is a sub-type of gender identity
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51 disorder (although is not explicitly termed as the most extreme sub-type), but GD is not a
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53 diagnosis in the manual. In the *DSM-IV*’s GID diagnosis there is no sub-type of transsexualism.
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The *DSM-5*'s definition of GD is not synonymous with *ICD-10* definitions. In, particular the *ICD-10* does not require that distress be present. Transsexualism is therefore neither a sub-type of GD nor a direct analogue in any diagnostic manual even though a large amount of papers seen in Table 13 deem it to be the same phenomena.

Gender dysphoria and 'Disorders of Sex Development'

A somewhat separate narrative relates to people with intersex conditions (often termed DSD in the literature, although this is disputed term. see ⁶⁰ Some papers explicitly stated that GD and intersex were distinct. However, the new diagnostic criteria allows psychiatrists to diagnose GD for people with intersex conditions comparably to trans people. Much of the medical literature regarding GD and intersex conditions in this review focused upon decisions around birth assignation, and the possibility that 'gender dysphoria' might occur later. The application of the term GD for those with variations of sex development⁶¹ serves a euphemizing function, disguising the responsibility of medical professionals and parents who take decisions to socially and surgically assign young children to a gender category and, in many cases, utilize medical interventions to 'normalize' the morphology of the body. Most authors did not discuss ethical questions about assigning intersex people a gender or using clinical interventions, despite an acknowledgement that subsequent distress with the gender assignation was a possible outcome.

Diagnosing GD as a consequence of clinical childhood interventions with intersex people raises fundamental questions about the original assignment by doctors and/or parents. However, none of the papers referred to this. The fact that some intersex people who later experience clinically significant distress or impairment related to their gender in these cases renders assignment at birth practices problematic. Further, the popular narrative of gender dysphoria is

that it is distress arising from incongruence between people's experienced gender identity and their 'biological' sex. However, intersex people, by definition, have biological characteristics that do not entirely align with classifications of a male or female sex. How then can congruence or incongruence between biology and identity be correctly defined within these (9.5% see Table 15) papers? The lack of evidence underpinning the diagnosis of GD in the DSM-5 in relation to intersex people is obvious here. Few texts centered on intersex people's own feelings or experiences regarding their identity. Rather, their GD feelings or experiences were discussed within a biomedical paradigm and, thus, cannot contribute to the content validity of GD as distress or impairment in social functioning.

Conclusion

We have drawn together some of the main narrative characterizations of GD from 387 articles and highlighted three key themes: distress and diagnosis; types of people; and popular discourse. While the stated intention of the *DSM-5* was to focus diagnosis upon distress and impairment, we have demonstrated that this is inconsistently applied within the literature. Some papers ignore the reference to distress entirely, while others imply distress where it may never have been present, or may have subsided. Frequent changes of terminology, and crossover between medicalized and identity terms, appear to have contributed to conflation and confusion to the extent that gender dysphoria is sometimes referred to as a specific diagnosis; sometimes as a phenomenological experience of distress; and sometimes as a personal characteristic within individuals. This diverse usage of 'gender dysphoria', and the application of the concept to populations who may neither meet diagnostic criteria nor experience distress may potentially undermine the stated intention of the APA that the new diagnosis of gender dysphoria would reduce pathologisation.

We have also pointed to the replication within the academic literature of popular discourses of gender dysphoria, rooted in normative assumptions about which forms of medical intervention with regard to bodily sex development should be treated as uncontroversial and inherently justified, and which should be seen as requiring special justification. The *DSM-5*'s re-definition of GD does not appear to have resolved concerns with regard to the scientificity or content validity of the diagnosis related to medical transition or intersex experiences.

Appropriate terminology with regard to gender diversity has been a longstanding and frequently fraught debate. There has been broad support for the APA's explicit recognition that gender diversity should not be universally pathologized and that the focus of health and social care professionals should be upon reducing distress and impairment in order to facilitate gender diverse people's equitable participation within society. However, these positive aims are most likely to be fulfilled if concepts of 'gender dysphoria' are clearly defined by clinicians, researchers, theorists and publishers, underpinned by robust evidence, critical analysis and peer review that is rooted within the lived experience of gender diverse people and communities.

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Table 1 Initial Search Results

database	results	database	results	database	results
NewsBank	2,258	TDX	26	SwePub	3
ScienceDirect	941	Humanities International Index	24	Research Starters	3
PsycINFO	413	Japanese Periodical Index	10	MLA International Bibliography	3
CINAHL Complete	382	British Library EThOS	6	Airiti Library eBooks & Journals	2
MEDLINE	299	Credo Reference Collections	6	Informit Health Collection	2
Newswires	268	Harvard Library Bibliographic Dataset	6	RACO	2
PsycARTICLES	216	SciELO	6	ERIC	2
Social Sciences Citation Index	167	Oxford Reference	5	RECERCAT	1
Science Citation Index	144	Arts & Humanities Citation Index	5	British Education Index	1
Business Source Complete	135	Teacher Reference Center	5	Alexander Street Press	1
LexisNexis Academic: Law Reviews	108	Art Full Text (H.W. Wilson)	4	Bibliotheksverbund Bayern	1
Food Science Source	107	Informit Humanities & Social Sciences Collection	4	JSTOR Journals	1
SPORTDiscus	86	International Bibliography of Theatre & Dance with	4	Oxford Handbooks Online	1

		Full Text			
PsycBOOKS	40	Library, Information Science & Technology Abstracts	4		
HeinOnline	31	PsycCRITIQUES	3		
OAlster	26	RCAAP	3		

For Peer Review

Table 2 Analyzed Articles

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